DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on October 6, 2009 at the College of Nurses of Ontario (“the College”) at Toronto.

The Allegations

The allegations against Mary McLean (the “Member”) as stated in the Notice of Hearing dated July 23, 2009, are as follows.

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of Ontario Regulation 799/93, in that, while employed by [the Agency] in [ ], Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to abandoning [the Client], who required continuing care, at approximately 4:00 a.m. on or about August 10, 2008.

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(5) of Ontario Regulation 799/93, in that,
while employed by the Agency in [ ], Ontario, you discontinued professional services that were needed by the Client at approximately 4:00 a.m. on or about August 10, 2008, without making other arrangements as required.

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of Ontario Regulation 799/93, in that, while employed by the Agency in [ ], Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional with respect to abandoning the Client, who required continuing care, at approximately 4:00 a.m. on or about August 10, 2008.

Member’s Plea

The Member admitted the allegations set out in paragraphs numbered 1 and 2 in the Notice of Hearing. For allegation #3, the Member admitted to professional misconduct that would reasonably be considered by members of the profession as dishonourable and unprofessional. The panel received a written plea inquiry which was signed by the Member. The panel also conducted an oral plea inquiry and was satisfied that the Member’s admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts which provided as follows.

THE MEMBER

1. The Member, Mary Elizabeth McLean (the “Member”) is a Registered Practical Nurse. The Member has been registered with the College of Nurses of Ontario (the “College”) since January 1, 1982. The Member is up-to-date with her annual fees.

2. The Member was hired as a Staff Nurse with the Agency on or about November 4, 1990. As a Staff Nurse, the Member was responsible for providing nursing care to clients in their homes.

3. The Member’s employment was terminated by the Agency on August 11, 2008, as a result of the incident described below.

4. The Member has no prior discipline history with the College.

THE AGENCY
5. The Agency provides Home Care Services that include a full range of comprehensive and specialty nursing services, personal support services, geriatric services, and pediatric care.

6. The Agency was providing nursing services to [the Client] in August 2008.

THE CLIENT

7. [The Client] was [ ] years old at the time of the incident. She resides with her parents. [The Client] is wheelchair-bound and is fully dependent on caregivers for her activities of daily living. She also is non-verbal.

8. [The Client] suffers from [numerous disorders]. As a result of [the Client]’s health conditions, she requires nursing care at night because she is at risk of aspiration. She is on continuous night feeds via a Gastro-Jejunal (GJ) tube and also requires suctioning as needed.

9. [The Client’s parent] is blind.

INCIDENT RELEVANT TO THE ALLEGATIONS OF PROFESSIONAL MISCONDUCT

10. The Member was assigned by the Agency to provide overnight home care to [the Client] on August 9 - 10, 2008. The Member’s shift was to start at 2300 hours on August 9, 2008 and end at 0700 hours on August 10, 2008. The Member had also provided care to [the Client] on the previous evening.

11. At approximately 0400 hours the morning of August 10, 2008, a massive explosion occurred [ ] several blocks away from [the Client]’s home.

12. According to [the Client’s parent], the explosions were very powerful and it felt “like the earth was shattering.” When the explosions occurred, it rocked their home. [The Client’s parent] came out of his bedroom where he and his [spouse] were sleeping at the time and into the hallway. His wife went to check on [the Client].

13. [The Client’s parent] called out to the Member to ask her what was happening. The Member went past him and out the front door of the house. The Member advised [the Client’s parent] that she believed there was a gas leak and that all of the houses were exploding. [The Client’s parent] concluded he had to get his family out of the home and to safety as soon as possible. The Member went back into the house and grabbed her purse and jacket. At [the parent]’s request, she retrieved the suctioning equipment for [the Client].
14. If she testified, the Member would state that she assisted the parents to move [the Client] from her bed to the wheelchair. She then retrieved the GJ apparatus and suction equipment. At the request of [the Client’s other parent], the Member moved her car out of the driveway so that [the Client] could be evacuated in their car. While the parents waited at the side door, the Member got in her car and drove away.

15. The Member did not assist [the Client] or her parents to evacuate the home. She did not seek any assistance for them from the Agency or any emergency services, and she did not report the incident to the Agency until the end of her shift.

16. According to [the Client’s parent], he and his [spouse] managed to get [the Client] into her wheelchair, down the stairs and out of the house. They made their way to a nearby apartment building where they dialled 911. Emergency Medical Services transported [the Client] to the hospital for ongoing care. In the midst of the evacuation, they had to leave medications and equipment essential for [the Client]’s ongoing care at their home.

17. [The Client’s parent] telephoned the Agency at approximately 0600 hours on August 10, 2008. He spoke with on-call staff at the Agency and reported what had happened. He advised that the Member had left him and his family to evacuate themselves during a propane explosion and fire. [The parent] was very upset that they had been abandoned by the Member.

18. The Member telephoned the Agency at approximately 0700 hours on August 10, 2008, to report what had happened, three hours after she had left [the Client] and her parents at their home. She advised the Agency that she left [the Client]’s home at approximately 0400 hours because of the gas explosion. The Member did not contact [the Client’s parents] to check on [the Client] between the time she left their home and the time she telephoned the Agency.

19. If she testified, the Member would state that she felt threatened by the gas explosion and she could only think of escaping the area. The Member drove several blocks from the home and stopped at a gas station where she purchased gas. She had a cell phone with her but did not call for assistance for [the Client] or her family. After filling up her car, the Member drove out of the area and eventually arrived at her home [ ]. She cannot explain why she took no action to assist [the Client] and her family, or why she did not call for assistance, other than to say she must have been affected by the gas explosion.

20. The Member acknowledges that her conduct following the gas explosion on August 10, 2008 was improper. She recognizes that she had a
professional obligation to assist [the Client] and that she failed to do so. The Member also acknowledges that her conduct is not excused because she felt threatened by the gas explosion.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

21. The Member admits that she has committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c.32, as amended, and defined in subsection 1(1) of Ontario Regulation 799/93, in that, while employed by [the Agency] in [ ], Ontario, she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to abandoning [the Client] who required continuing care, at approximately 4:00 a.m. on August 10, 2008.

22. The Member admits that she has committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(5) of Ontario Regulation 799/93, in that, while employed by [the Agency] in [ ], Ontario, she discontinued professional services that were needed by [the Client] at approximately 4:00 a.m. on August 10, 2008, without making other arrangements as required.

23. The Member admits that she has committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c.32, as amended, and defined in subsection 1(37) of Ontario Regulation 799/93, in that, while employed by [the Agency] in [ ], Ontario, she engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably regarded by members of the profession as dishonourable and unprofessional with respect to abandoning [the Client], who required continuing care, at approximately 4:00 a.m. on August 10, 2008.

A member of the panel, upon hearing the facts, disclosed that they possibly knew the [Client] but was not aware of the incident and has not cared for [the Client]. College Counsel and the Member’s Legal Agent had no objections to the panel member remaining.

Decision

The panel considered the Agreed Statement of Facts and finds that the facts support a finding of professional misconduct and, in particular, finds that the Member committed an act of professional misconduct as alleged in paragraphs #1, 2, and 3 of the Notice of Hearing in that she abandoned her [client] and she did not make arrangements for the care of the client. She engaged in professional misconduct that would be regarded by members of the profession as dishonourable and unprofessional.
**Reasons for Decision**

The panel accepted the Agreed Statement of Facts as reasons for its decision. With respect to allegation #1, the panel found the evidence in paragraphs 10, 13, 14, 15, and 19 of the Agreed Statement of Facts supported the decision. With respect to allegation #2, the panel found the evidence in paragraphs 17, 18, 19, and 20 supported the decision. With respect to allegation #3, the panel agrees that based on the facts presented, the member engaged in conduct that would be reasonably considered by members of the profession as dishonourable and unprofessional.

**Penalty**

Counsel for the College advised the panel that a Joint Submission as to Order had been agreed upon. The Joint Submission as to Order proposes that the panel make an order:

1. Requiring the Member to appear before the Panel to be reprimanded at a date to be arranged but, in any event, within three (3) months of the date this Order.

2. Directing the Executive Director to suspend the Member’s certificate of registration for a period of three (3) months. This suspension shall take effect from the date of this Order and shall continue to run without interruption. The suspension shall run continuously so long as the Member maintains a current registration. In the event that the Member fails to maintain a current registration, any portion of the suspension which has not yet been served, shall be served commencing on the day that the registration is renewed.

3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member’s certificate of registration:

   a. The Member shall return her current Annual Payment Card to the College within fourteen (14) days of the date of this Order so that a new Annual Payment Card, indicating that the Member’s certificate of registration is subject to terms, conditions and/or limitations, can be issued upon completion of the suspension. The Member’s Annual Payment Card shall be delivered to the College by a verifiable method of delivery, the proof of which the Member shall retain;

   b. The Member shall attend two (2) meetings with an Expert with expertise in Therapeutic Nurse-Client Relationships (the “Expert”) who has received the prior approval of the Director, Professional Conduct (the “Director”). All costs associated with these meetings shall be borne by the Member. The meetings shall commence within three (3) months of the date of the Order. The second meeting shall take place within two (2) months of the first meeting and all two (2) meetings shall be completed within six (6) months of the date of the Order;

   c. Prior to the commencement of the meetings referred to in paragraph 3(b), above, the Member shall:
i. provide the Expert with a copy of the Discipline Panel’s Order, the Agreed Statement of Facts, the Joint Submission on Order, and the Panel’s written Decision and Reasons, if available, delivered through the use of a verifiable method of delivery, the proof of which the Member shall retain. If the Panel’s Decision and Reasons are not available prior to the Member’s first meeting with the Expert, the Member shall deliver to the Expert, through the use of a verifiable method of delivery, the proof of which the Member shall retain, a copy of the Panel’s Decision and Reasons within 14 days of their release;

ii. Review the following College publications and complete a Reflective Questionnaire for each publication: *Professional Standards, Revised 2002; Ethics; and Refusing Assignments and Discontinuing Nursing Service*. The Member shall bring the completed Reflective Questionnaires to her meetings with the Expert;

iii. Complete the College’s online learning modules relating to *Professional Standards* and *Ethics*, complete the online participation form relevant to each module, and print and bring the completed online participation forms to her meetings with the Expert; and

iv. Deliver to the Expert by a verifiable method of delivery copies of the completed Reflective Questionnaires for each publication and completed online participation form as set out in paragraphs 3(c)(ii) and (iii) above, at least seven (7) days prior to her meeting with the Expert.

d. The subject of the meetings with the Expert will include the following:

i. The conduct for which the Member was found to have committed professional misconduct;

ii. The potential consequences of that conduct to her clients, her colleagues, her profession and herself;

iii. The responsibilities the Member has as a regulated health professional, particularly in times of crisis;

iv. Strategies for making the inappropriate conduct unlikely to occur in the future; and

v. Development of a learning plan.

e. During the first meeting with the Expert, the Member shall develop a learning plan in consultation with the Expert to address the subject of the meetings as set out in paragraphs 3(d)(i) to 3(d)(v) above;
f. During the second meeting with the Expert, the Member and the Expert shall further discuss the subject of the meetings as set out in paragraphs 3(d)(i) to 3(d)(v) above and, if applicable, the implementation of the learning plan;

g. Once the Member has completed all the meetings with the Expert referred to in paragraph 3(b), above, the Director shall receive from the Expert within forty-five (45) days a report, delivered through the use of a verifiable method of delivery, proof of which the Expert shall retain, in which the Expert confirms:

i. that the Member has attended the meetings with the Expert;

ii. that the subject of the meetings were the Member’s inappropriate conduct, the consequences of this behaviour in the nursing context, the responsibilities the Member has as a regulated health professional, particularly in times of crisis, the strategies for making the inappropriate conduct unlikely to occur in the future and the development of a learning plan with the Member;

iii. her/his assessment of the Member’s insight into her behaviour; and

iv. that she/he received copies of the Discipline Panel’s Order, the Agreed Statement of Facts, the Joint Submission on Order, and, if available, the Panel’s Decision and Reasons;

h. For a period of twelve (12) months following the date upon which the Member returns to the practice of nursing, the Member shall:

i. notify the Director of the name, address, and telephone number of all employer(s) within fourteen (14) days of commencing or resuming employment in any nursing position. Notification shall be in writing and through the use of a verifiable method of delivery, the proof of which the Member shall retain;

ii. provide her employer(s) with a copy of the Discipline Panel’s Order and the Notice of Hearing, the Agreed Statement of Facts, the Joint Submission on Order or, if available, the Discipline Panel’s written Decision and Reasons. If the Decision and Reasons are not available on the day that the Member returns to practice, the Member shall provide her employer with a copy of the Decision and Reasons within fourteen (14) days of it becoming available;

iii. review any Emergency, Pandemic and/or Evacuation policies of all employer(s) within fourteen (14) days of commencing or resuming employment in any nursing position.

iv. only practi[s]e for an employer(s) who agrees to, and does write to the Director, within fourteen (14) days of the commencement or
resumption of the Member’s employment and provide the Director with the following:

a. confirmation that the employer(s) has received a copy of the documents referred to in paragraph 3(h)(ii) above;

b. confirmation that the Member has been provided with and has reviewed any Emergency, Pandemic and/or Evacuation policies of the employer; and

c. confirmation that the employer agrees to notify the Director immediately upon receipt of any reasonable information that the Member has breached the standards of practice of the profession.

Penalty Submissions

Counsel for the College asked that the proposed penalty be adopted by the panel. He submitted that, considering the seriousness of the Member’s actions, the proposed order is appropriate in that it provides for a reprimand, suspension, and terms, conditions, and limitations that meet the requirements of the College’s mandate to protect the public. Aggravating circumstances include the seriousness of the conduct. The Member abandoned her client and made no effort to obtain assistance for the family. Although she had a cell phone, she did not use it. She claimed she was afraid after the explosion, but gave no compelling reason for why she left. She did not stay to assist her client, and fled the scene. She did, however, pause long enough to fill the gas tank of her car. Mitigating circumstances included that she has accepted responsibility for her actions, admitted her guilt, and negotiated a resolution with the College. She has no prior discipline history with the College.

The proposed penalty provides for specific deterrence in that the Member will receive a reprimand and suspension, and puts terms, conditions and limitations on her practice after she completes her suspension. The proposed penalty provides general deterrence to the members of the profession, sending the message that such conduct is not acceptable. Rehabilitation is provided through remedial counselling with an expert in professional practice. The outcomes must be reported back to the Director of [Professional Conduct]. The interest of the public is met through clear sanctions on the Member’s practice. The proposed penalty demonstrates that this behaviour cannot be condoned or allowed by any member of the profession.

The Legal Agent for the Member agreed with College Counsel’s submissions. He submitted further mitigating factors. The Member felt she was a victim of a traumatic event and has not been able to work since. She has an over 20-year nursing career with an unblemished record. Her actions were not deliberate, considered, or planned. People panic in these circumstances and the Member’s conduct was not thought out. The Member has no history of abandonment or breaching rules of the profession, and the behaviour was out of character. There is no pattern of uncaring attitude to her obligations as a nurse.
This is a unique and unprecedented situation. The Member made sure the suction machine was available, the client was in her wheelchair, and the feeding was prepared. Her panic occurred when asked to move her car from the driveway so the family could get out. Her automatic reaction was to drive away from the scene of danger. She felt the family was safe. Since the event, she has been receiving medical and psychiatric care to deal with the events of that night. The Member’s Agent indicated the Member did not immediately call her agency as her cell phone was lost in her car; she did call the agency upon arriving home at 0700.

The Agent submitted that the Terms and Conditions are harsh and may limit the Member’s ability to obtain employment in her profession. Specific deterrence has been achieved through the results of the trauma from which the Member suffered.

In reply, College Counsel submitted that the panel needs to be careful to only consider the facts as set out in the Agreed Statement of Facts (ASF) and cannot include any comments of the Legal Agent that were not included in the ASF and which derogate from the ASF.

**Penalty Decision**

The panel accepts the Joint Submission on Order dated October 6, 2009 and accordingly orders:

1. The Member to appear before the Panel to be reprimanded at a date to be arranged but, in any event, within three (3) months of the date of this Order.

2. The Executive Director to suspend the Member’s certificate of registration for a period of three (3) months. This suspension shall take effect from the date of this Order and shall continue to run without interruption. The suspension shall run continuously so long as the Member maintains a current registration. In the event that the Member fails to maintain a current registration, any portion of the suspension which has not yet been served, shall be served commencing on the day that the registration is renewed.

3. The Executive Director to impose the following terms, conditions and limitations on the Member’s certificate of registration:
   a. The Member shall return her current Annual Payment Card to the College within fourteen (14) days of the date of this Order so that a new Annual Payment Card, indicating that the Member’s certificate of registration is subject to terms, conditions and/or limitations, can be issued upon completion of the suspension. The Member’s Annual Payment Card shall be delivered to the College by a verifiable method of delivery, the proof of which the Member shall retain;
   b. The Member shall attend two (2) meetings with an Expert with expertise in Therapeutic Nurse-Client Relationships (the “Expert”) who has received the prior approval of the Director, Professional Conduct (the “Director). All costs associated with these meetings shall be borne by the Member. The meetings shall commence within three (3) months of the date of the Order. The second meeting shall take place within two (2) months of the first meeting and all two (2) meetings shall be completed within six (6) months of the date of the Order;
c. Prior to the commencement of the meetings referred to in paragraph 3(b), above, the Member shall:

i. provide the Expert with a copy of the Discipline Panel’s Order, the Agreed Statement of Facts, the Joint Submission on Order, and the Panel’s written Decision and Reasons, if available, delivered through the use of a verifiable method of delivery, the proof of which the Member shall retain. If the Panel’s Decision and Reasons are not available prior to the Member’s first meeting with the Expert, the Member shall deliver to the Expert, through the use of a verifiable method of delivery, the proof of which the Member shall retain, a copy of the Panel’s Decision and Reasons within 14 days of their release;

ii. Review the following College publications and complete a Reflective Questionnaire for each publication: Professional Standards, Revised 2002; Ethics; and Refusing Assignments and Discontinuing Nursing Service. The Member shall bring the completed Reflective Questionnaires to her meetings with the Expert;

iii. Complete the College’s online learning modules relating to Professional Standards and Ethics, complete the online participation form relevant to each module, and print and bring the completed online participation forms to her meetings with the Expert; and

iv. Deliver to the Expert by a verifiable method of delivery copies of the completed Reflective Questionnaires for each publication and completed online participation form as set out in paragraphs 3(c)(ii) and (iii) above, at least seven (7) days prior to her meeting with the Expert.

d. The subject of the meetings with the Expert will include the following:

i. The conduct for which the Member was found to have committed professional misconduct;

ii. The potential consequences of that conduct to her clients, her colleagues, her profession and herself;

iii. The responsibilities the Member has as a regulated health professional, particularly in times of crisis;

iv. Strategies for making the inappropriate conduct unlikely to occur in the future; and

v. Development of a learning plan.

e. During the first meeting with the Expert, the Member shall develop a learning plan in consultation with the Expert to address the subject of the meetings as set out in paragraphs 3(d)(i) to 3(d)(v) above;
f. During the second meeting with the Expert, the Member and the Expert shall further discuss the subject of the meetings as set out in paragraphs 3(d)(i) to 3(d)(v) above and, if applicable, the implementation of the learning plan;

g. Once the Member has completed all the meetings with the Expert referred to in paragraph 3(b), above, the Director shall receive from the Expert within forty-five (45) days a report, delivered through the use of a verifiable method of delivery, proof of which the Expert shall retain, in which the Expert confirms:

i. that the Member has attended the meetings with the Expert;

ii. that the subject of the meetings were the Member’s inappropriate conduct, the consequences of this behaviour in the nursing context, the responsibilities the Member has as a regulated health professional, particularly in times of crisis, the strategies for making the inappropriate conduct unlikely to occur in the future and the development of a learning plan with the Member;

iii. her/his assessment of the Member’s insight into her behaviour; and

iv. that she/he received copies of the Discipline Panel’s Order, the Agreed Statement of Facts, the Joint Submission on Order, and, if available, the Panel’s Decision and Reasons;

h. For a period of twelve (12) months following the date upon which the Member returns to the practice of nursing, the Member shall:

i. notify the Director of the name, address, and telephone number of all employer(s) within fourteen (14) days of commencing or resuming employment in any nursing position. Notification shall be in writing and through the use of a verifiable method of delivery, the proof of which the Member shall retain;

ii. provide her employer(s) with a copy of the Discipline Panel’s Order and the Notice of Hearing, the Agreed Statement of Facts, the Joint Submission on Order or, if available, the Discipline Panel’s written Decision and Reasons. If the Decision and Reasons are not available on the day that the Member returns to practice, the Member shall provide her employer with a copy of the Decision and Reasons within fourteen (14) days of it becoming available;

iii. review any Emergency, Pandemic and/or Evacuation policies of all employer(s) within fourteen (14) days of commencing or resuming employment in any nursing position.

iv. only practice for an employer(s) who agrees to, and does write to the Director, within fourteen (14) days of the commencement or resumption of the Member’s employment and provide the Director with the following:

a. confirmation that the employer(s) has received a copy of the documents referred to in paragraph 3(h)(ii) above;
b. confirmation that the Member has been provided with and has reviewed any Emergency, Pandemic and/or Evacuation policies of the employer; and

c. confirmation that the employer agrees to notify the Director immediately upon receipt of any reasonable information that the Member has breached the standards of practice of the profession.

Reasons for Penalty Decision

The panel concluded that the proposed penalty is reasonable and in the public interest. The Member has cooperated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility for her actions.

The panel agrees that the terms provide for rehabilitation and remediation of the Member. The Member has the opportunity to engage in reflection and learning with the guidance of an expert. The penalty provides for specific deterrence through the suspension and terms and limitations, and the requirement to report after the suspension is complete. It provides for general deterrence by sending a clear message to members of the profession that abandoning clients even when in a stressful situation is not acceptable. The Order fulfills the College’s mandate to protect the public, and to protect the public trust by demonstrating that the profession of nursing is capable of governing itself.

I, Michael Hogard, RPN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

Panel Members:

Angela Verrier, RPN
Karen Breen-Reid, RN
Margaret Tuomi, Public Member
Abdul Patel, Public Member